Guidelines for Interviewing Resident (continued)

For example:

After you retired from your job, did you get up at a regular time in the morning?
When did you usually get up in the morning?
What was the first thing you did after you arose?
What time did you usually have breakfast?
What kind of food did you like for breakfast?
What happened after breakfast? (Probe for naps or regular post-breakfast activity such as reading the paper, taking a walk, doing chores, washing dishes.)
When did you have lunch? Was it usually a big meal or just a snack?
What did you do after lunch? Did you take a short rest? Did you often go out or have friends in to visit?
Did you ever have a drink before dinner? Every day? Weekly?
What time did you usually bathe? Did you usually take a shower or a tub bath?
How often did you bathe? Did you prefer AM or PM?
Did you snack in the evening?
What time did you usually go to bed? Did you usually wake up during the night?

Definition: **CYCLE OF DAILY EVENTS**

a. Stays Up Late at Night (e.g., after 9 pm)

b. Naps Regularly During Day - At least 1 hour

c. Goes Out 1+ Days a Week - Went outside for any reason (e.g., socialization, fresh air, clinic visit).

d. Stays Busy with Hobbies, Reading, or Fixed Daily Routine

e. Spends Most of Time Alone or Watching TV

f. Moves Independently Indoors (with Appliances, if used)

g. Use of Tobacco Products at Least Daily - Used any type of tobacco (e.g., cigarettes, cigars, pipe) at least once daily. This item also includes sniffing or chewing tobacco.

h. ***NONE OF ABOVE***

EATING PATTERNS

i. Distinct Food Preferences - This item is checked to indicate the presence of specific food preferences, with details recorded elsewhere in the clinical record (e.g., was a vegetarian; observed kosher dietary laws; avoided red meat for health reasons; allergic to wheat and avoids bread, etc.). *Do not check this item for simple likes and dislikes*.

j. Eats Between Meals All or Most Days

k. Use of Alcoholic Beverage(s) at Least Weekly - Drank at least one alcoholic drink per week.

l. ***NONE OF ABOVE***

ADL PATTERNS

m. In Bedclothes Much of Day

n. Wakens to Toilet All or Most Nights - Awoke to use the toilet at least once during the night all or most of the time.

o. Has Irregular Bowel Movement Pattern - Refers to an unpredictable or variable pattern of bowel elimination, regardless of whether or not the resident prefers a different pattern.

p. Showers for Bathing

q. Bathing in PM - Took shower or bath in the evening.

r. ***NONE OF ABOVE***

INVOLVEMENT PATTERNS

s. Daily Contact with Relatives/Close Friends - Includes visits, telephone calls, regular e-mail. Does not include exchange of letters only.

t. Usually Attends Church, Temple, Synagogue (etc.) - Refers to interaction regardless of type (e.g., regular churchgoer, watched TV evangelist, involved in church or temple committees or groups).

u. Finds Strength in Faith

v. Daily Animal Companion/Presence - Refers to involvement with animals (e.g. house pet, seeing-eye dog, fed birds daily in yard or park).

w. Involved in Group Activities

x. ***NONE OF ABOVE***

y. ***UNKNOWN*** **-** If the resident cannot provide any information, no family members are available, and the admission record does not contain relevant information, check the last box in the category ("UNKNOWN"). Leave all other boxes in Section AC blank.

Coding: Coding is limited to selected routines in the year prior to the resident's first admission to a nursing facility. *Code the resident's actual routine rather than his or her goals or preferences* (e.g., if the resident would have liked daily contact with relatives but did not have it, do not check "Daily contact with relatives/close friends").

Under each major category (Cycle of Daily Events, Eating Patterns, ADL Patterns, and Involvement Patterns) a *NONE OF ABOVE* choice is available. For example, if the resident did not engage in any of the items listed under Cycle of Daily Events, indicate this by checking *NONE OF ABOVE* for Cycle of Daily Events.

If an individual item in a particular category is not known (e.g. "Finds strength in faith," under Involvement Patterns), enter "**-**".

If information is unavailable for all the items in the entire Customary Routine section, check the final box "UNKNOWN" - Resident/family unable to provide information. If UNKNOWN is checked, no other boxes in the Customary Routine section should be checked.

SECTION AD. FACE SHEET SIGNATURES

ADa. Signature of RN Assessment Coordinator

Coding: The RN Assessment Coordinator who worked on the *Background (Face Sheet) Information at Admission* must enter his or her signature on the day it is complete. Also, to the right of the name, enter the date the form was signed. If, for some technical reason, such as computer or printer breakdown, the *Background (Face Sheet) Information at Admission* cannot be signed on the date it is completed, it is appropriate to use the actual date it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record.

ADb-g. Signature of Others Who Completed Part of Background Assessment Sections AB and AC

Coding: All staff responsible for completing any part of the *Background (Face Sheet) Information at Admission* must enter their signatures, titles, sections they completed, and the date they completed those sections. Read the Attestation Statement carefully. You are certifying that the information you entered on the Background Face Sheet is correct. Penalties may be applied for submitting false information.

SECTION A. MDS IDENTIFICATION AND BACKGROUND INFORMATION

A1. Resident Name

Definition: Legal name in record.

Coding: Use printed letters. Enter in the following order:

a. First Name
b. Middle Initial; if the resident has no middle initial, leave Item b. blank.
c. Last Name
d. Jr./Sr.

A2. Room Number

Intent: Another identifying number for tracking purposes.

Definition: The number of resident's room in the facility.

Coding: Start in the left most box; use as many boxes as needed.

Example

N	3	0	5	

Mr. F lives in Room N305 at your facility. The N stands for New Building in your two building complex. The three hundred series of rooms are on the third floor.

A3. Assessment Reference Date

a. Last Day of MDS Observation Period

Intent: To establish a common reference point for all staff participating in the resident's assessment. As staff members may work on a resident's MDS assessment on different days, establishing the Assessment Reference Date ensures a common assessment period. In other words, the ARD designates the end of the observation period so that all assessment items refer to the resident's objective performance and health status during the same period of time.

Definition: This date refers to a specific end-point for a common observation period in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the Assessment Reference Date (ARD). Most frequently, the observation period is a 7-day period ending on this date. Some observation periods cover the 14 days ending on this date, and some cover 30 days ending on this date.

Clarifications:

- The ARD is the common date on which all MDS observation periods end. The observation period is also referred to as the look-back period. It is the time period during which data is captured for inclusion on the MDS assessment. The ARD is the last day of the observation period and controls what care and services are captured on the MDS assessment. Anything that happens after the ARD will not be captured on that MDS. For example, for an MDS item with a 7-day period of observation, assessment information is collected for 7 days prior to and including the date in Item A3a; for a 14-Day assessment item, the observation period is the 14 days prior to and including the date at Item A3a.

- The Admission assessment must be completed by day 14 of the stay with the date of admission counted as day 1. All other assessments must be completed within 14 days of the ARD (Item A3a). For example, if Item A3a was set for December 8th, the latest completion date for this assessment would be December 22nd (i.e., December 8 plus 14 days = December 22). Another way of looking at this is if the ARD is counted as Day 1, then the completion date can be as late as Day 15.

  NOTE: Medicare Fiscal Intermediaries have often used the term "completion date" differently when applied to SNF payment. For Part A billing, the RUG-III payment rate may be adjusted on the ARD of a non-scheduled assessment; e.g., Significant Change in Status or OMRA. In these situations, the ARD of the non-scheduled assessment has sometimes been referred to as the completion date, and is used to indicate a change in the RUG-III group used for payment.

- Staff actually completes the MDS in the period of time between the ARD and the MDS Completion Date, Item R2b. It is allowable for the ARD to be the same as the MDS Completion Date in Item R2b. It may be more practical, although not a Federal requirement, to leave some time between the ARD date and the completion date. Assessments must be completed, signed (R2a) and dated (R2b) within:

  - 14 days of admission for an Admission assessment (AB1) or Readmission (A4a);
  - 14 days of the ARD for all other assessments.

- When the resident dies or is discharged prior to the end of the observation period for a required assessment, the ARD must be adjusted to equal the discharge date. Generally, facilities are required to complete these assessments after the resident's discharge in order to bill for Medicare or Medicaid payment. In this situation, changing the ARD would normally shorten the observation period. Since some facilities prefer to use data for a full observation period, even if it means collecting more information on the resident's condition prior to admission to the nursing facility, CMS has established an option that would allow the nursing facility to establish a full observation period.

  Option 1 - Change the ARD to the date of discharge, but complete the MDS using less than a full observation period. In this case, the Assessment Reference Date had been set at Day 5, and the resident was discharged after 4 days of the observation period. For items with a 7-day observation period, the MDS would be completed using the data collected for the 4-day period in the nursing facility and the 2-day period prior to admission.

  Option 2 - Change the ARD to the date of discharge, but extend the observation period prior to the date of admission, and collect additional data to complete the assessment. Generally, this expanded observation period would require additional data from the prior hospital stay. In this example, if the resident was discharged after 4 days, the MDS would be completed using the data collected for the 4-day period in the nursing facility. For a 7-day assessment item, hospital data could be used for the 3-day period prior to the nursing facility admission.

  Nursing facility providers must select one of these options and apply it consistently in all cases where the resident is discharged prior to the end of the observation period. It is not appropriate to change options on a case-by-case basis in order to increase reimbursement.

- The observation period may not be extended simply because a resident was out of the facility during a portion of the observation period; e.g., a home visit or therapeutic leave. If the Assessment Reference Date is set at Day 14, and there is a 2-day temporary leave during the observation period, the two leave days are still considered part of the observation period. When collecting assessment information, you will not have data for two of the days in the observation period. This procedure applies to all assessments, regardless of whether or not they are being completed for clinical or payment purposes.

- If the resident is admitted to the hospital prior to completing the Admission assessment, and returns to the facility, the facility staff may choose to complete the original Admission assessment or start a new assessment. If the staff chooses to complete the original assessment, then the original Assessment Reference Date must be retained and staff must properly identify those MDS items that can be coded only when furnished during the nursing facility stay. For example, services such as therapy or doctor visits occurring during the resident's hospital stay would not be coded on the MDS. The facility can also choose to start a new assessment upon the resident's return. The facility would then have 14 days from the return date (A4a) to perform the Admission assessment.

  If the resident was in a Medicare Part A stay prior to the hospitalization, the facility will generally complete all or part of a 5-Day Medicare assessment in order to establish a RUG-III group for payment purposes. Then, when the beneficiary returns, the facility will complete a Medicare 5-Day Readmission/Return assessment (Item A8b=5). The Medicare Readmission/Return assessment may be combined with the Admission assessment.

Coding: Complete the boxes with the appropriate date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0". Use four digits for the year. For example, August 2, 2002 should be entered as:

0	8

Month

0	2

Day

2	0	0	2

Year

b. Original (00) or Corrected Copy of Form: Always enter a (00) in this item. It is not used in the correction process. See Chapter 5 for information on the correction process.

A4a. Date of Reentry

This item appears on the MDS Reentry Tracking form. See Chapter 1 for copies of this form.

Intent: To track the date of the resident's return to the facility following a discharge-return anticipated.

Definition: The date the resident most recently returned to your facility after being discharged with return anticipated for hospital stay in last 90 days (or since last assessment or admission if less than 90 days).

Process: Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department.

Coding: If the resident has not been hospitalized in last 90 days, leave blank. Otherwise, use all boxes. For a one-digit month or day, place a zero in the first box. For example: February 3, 2002, should be entered as:

0	2	-	0	3	-	2	0	0	2
Month			Day			Year			

A4b. Admitted From at Reentry

This item appears on the MDS Reentry Tracking form-see forms in Chapter 1.

Definition:

1. **Private Home or Apartment** - Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities, and independent housing for the elderly.

2. **Private Home/Apt. with Home Health Services** - Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

3. **Board and Care/Assisted Living/Group Home** - A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.

4. **Nursing Home** - An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for injured, disabled or sick persons.

5. **Acute Care Hospital** - An institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled or sick persons.

6. **Psychiatric Hospital, MR/DD Facility** – A psychiatric hospital is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. An MR/DD facility is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities.

7. **Rehabilitation Hospital** - An Inpatient Rehabilitations Hospital (IRF) that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons.

8. **Other** - Includes hospices and chronic disease hospitals.

Process: Review admission records. Consult the resident and the resident's family.

Coding: Choose only one answer.

A5. Marital Status

Coding: Choose the answer that best describes the current marital status of the resident: **1.** Never Married, **2.** Married, **3.** Widowed, **4.** Separated, or **5.** Divorced.

A6. Medical Record Number

Definition: This number is the unique identifier assigned by the facility for the resident. If not on the medical record, it is available from the facility's admissions office, business office, or Health Information Management Department.

A7. Current Payment Source(s) for Nursing Home Stay

Intent: To determine payment source(s) that covers the daily per diem or ancillary services for the resident's stay in the nursing facility over the last 30 days.

Definition:

a. **Medicaid Per Diem** - Room, board, nursing care, activities, and services included in the routine daily charge. Check this item if Medicaid is pending.

b. **Medicare Per Diem** – Room, board, nursing care, activities, and services included in the routine daily charge.

c. Medicare Ancillary Part A - Services such as medications, equipment for treatments, or supplies billed outside of the daily routine per diem charge.

d. Medicare Ancillary Part B

e. CHAMPUS Per Diem – The resident's military insurance is covering daily charges.

f. VA Per Diem – The Veterans Administration has contracted with the facility to pay for the resident's daily charges.

g. Self or Family Pays for Full Per Diem - Includes full private pay by resident or family.

h. Medicaid Resident Liability or Medicare Co-Payment - The resident is responsible for a co-payment.

i. Private Insurance Per Diem (Including Co-Payment) - The resident's private insurance company is covering daily charges.

j. Other - Examples include Commission for the Blind, Alzheimer's Association.

Process: Check with the billing office to review current payment sources. Do not rely exclusively on information recorded in the resident's clinical record, as the resident's clinical condition may trigger different sources of payment over time. Usually business offices track such information.

Coding: Check all that apply. We recognize that many facility staff have had a lot of difficulty in reporting payment source. To a great extent, the problems are the result of lack of information; business office staff is more aware of secondary insurance coverage than clinical staff. For this reason, we are evaluating the usefulness of this item in our MDS 3.0 development. For now, please continue to use the definitions provided. When evaluating the accuracy of MDS coding at a facility, errors in just the Payment Source item should not be heavily weighted. If the clinical coding and key identifiers are coded accurately, Payment Source errors should not be cited as evidence of inaccurate MDS processing.

A8. Reasons for Assessment

Intent: To document the key reason for completing the assessment, using the various categories of assessment types mandated by Federal regulation. **For detailed information on the scheduling and timing of the assessments, see Chapter 2, Section 2.2.**

a. Primary Reason for Assessment

Definition:

1. Admission Assessment (required by day 14)

2. Annual Assessment

3. Significant Change in Status Assessment

4. Significant Correction of Prior Full (Comprehensive) Assessment

5. Quarterly Review Assessment

6. Discharged-Return Not Anticipated

7. Discharged-Return Anticipated

8. Discharged Prior to Completing Initial Assessment

9. Reentry

10. Significant Correction of Prior Quarterly Assessment

0. ***NONE OF ABOVE*** - Use this code when preparing Medicare assessments or when your State requires you to complete one of the additional assessment types referenced in Item AA8b (below). It indicates that the assessment has been completed to comply with State-specific requirements (e.g., case mix payment). Select the code under Item AA8b (below) that indicates the Medicare or State Reason for Assessment. Also, use this code when completing a PPS-only assessment or an assessment for another payer, such as an HMO.

Coding: Enter the number corresponding to the primary reason for assessment. This item contains 2 digits. For codes 1-9, leave the first box blank, and place the correct response in the second box. If you were coding this item for an OBRA-only assessment, you would not complete the Medicare Reasons for Assessment (AA8b). However, if you were combining an OBRA assessment with a Medicare assessment, you would have a code in both Items AA8a and AA8b.

b. Assessment Codes Used for the Medicare Prospective Payment System

Definition:

1. Medicare 5-Day Assessment

2. Medicare 30-Day Assessment

3. Medicare 60-Day Assessment

4. Medicare 90-Day Assessment

5. **Medicare Readmission/Return Assessment**

6. **Other State-Required Assessment**

7. **Medicare 14-Day Assessment**

8. **Other Medicare Required Assessment**

Coding: Enter the number corresponding to the assessment code used for the Medicare Prospective Payment System. It is possible to select a code from both AA8a and AA8b (e.g., Item AA8a = coded "3" [Significant Change in Status assessment], and Item AA8b = coded "3" [60-Day assessment]). See Chapter 2, Section 2.6 for details on combining assessments.

If there are two Medicare Reasons for Assessment, i.e., an OMRA combined with a regularly scheduled Medicare assessment, code Item AA8b = 8.

When the Primary Reason for Assessment is "00", and the Medicare Reason for Assessment is "6" or blank, the record is not edited or stored in the State MDS database. Facilities completing Medicare assessments on a standby basis should code AA8b as 1, 2, 3, 4, 5, or 7 to make sure that the assessments are properly edited and retained in the database.

A9. Responsibility/Legal Guardian

Intent: To record who has responsibility for participating in decisions about the resident's health care, treatment, financial affairs, and legal affairs. Depending on the resident's condition, multiple options may apply. For example, a resident with moderate dementia may be competent to make decisions in certain areas, although in other areas a family member will assume decision-making responsibility. Or a resident may have executed a limited power of attorney to someone responsible only for legal affairs. Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here are for general information only. Refer to the law in your state and to the facility's legal counsel, as appropriate, for additional clarification.

Definition: 1. **Legal Guardian** - Someone **who has been appointed after a court hearing** and is authorized to make decisions for the resident, including giving and withholding consent for medical treatment. Once appointed, only another court hearing may revoke the decision-making authority of the guardian.

2. **Other Legal Oversight** - Use this category for any other program in your state whereby someone other than the resident participates in or makes decisions about the resident's health care and treatment.

3. **Durable Power of Attorney/Health Care** - Documentation that someone other than the resident is legally responsible for health care decisions if the resident becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the resident's wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the resident at any time.

d. **Durable Power of Attorney/Financial** - Documentation that someone other than the resident is legally responsible for financial decisions if the resident becomes unable to make decisions.

e. **Family Member Responsible** - Includes immediate family or significant other(s) as designated by the resident. Responsibility for decision-making may be shared by both resident and family.

f. **Resident Responsible for Self** - Resident retains responsibility for decisions. In the absence of guardianship or legal documents indicating that decision-making has been delegated to others, always assume that the resident is the responsible party.

e. ***NONE OF ABOVE***

Process: Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here are for general information only. Refer to the law in your state and to the facility's legal counsel, as appropriate, for additional clarification.

Consult the resident and the resident's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the resident's record in order for the item to be checked on the MDS form.

Coding: Check all that apply.

A10. Advanced Directives

Intent: To record the legal existence of directives regarding treatment options for the resident, whether made by the resident or a legal proxy. Documentation must be available in the record for a directive to be considered current and binding. The absence of pre-existing directives for the resident should prompt discussion by clinical staff with the resident and family regarding the resident's wishes. Any

discrepancies between the resident's current stated wishes and what is said in legal documents in the resident's file should be resolved immediately.

Definition:

a. Living Will - A document specifying the resident's preferences regarding measures used to prolong life when there is a terminal prognosis.

b. Do Not Resuscitate - In the event of respiratory or cardiac failure, the resident, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the resident's respiratory or circulatory function.

c. Do Not Hospitalize - A document specifying that the resident is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

d. Organ Donation - Instructions indicating that the resident wishes to make organs available for transplantation, research, or medical education upon death.

e. Autopsy Request - Document indicating that the resident, family or legal guardian has requested that an autopsy be performed upon death. The family or responsible party must still be contacted upon the resident's death and re-asked if they want an autopsy to be performed.

f. Feeding Restrictions - The resident or responsible party (family or legal guardian) does not wish the resident to be fed by artificial means (e.g., tube, intravenous nutrition) if unable to be nourished by oral means.

g. Medication Restrictions - The resident or responsible party (family or legal guardian) does not wish the resident to receive life-sustaining medications (e.g., antibiotics, chemotherapy). These restrictions may not be appropriate, however, when such medications could be used to ensure the resident's comfort. In these cases, the directive should be reviewed with the responsible party.

h. Other Treatment Restrictions - The resident or responsible party (family or legal guardian) does not wish the resident to receive certain medical treatments. Examples include, but are not limited to, blood transfusion, tracheotomy, respiratory intubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (e.g., reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party.

i. ***NONE OF ABOVE***

Process: You will need to familiarize yourself with the legal status of each type of directive in your state. In some states only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and the appointment of individuals with durable power of attorney for health care decisions. Facilities should develop a policy regarding documents drawn in other states, respecting them as important expressions of the resident's wishes until their legal status is determined.

Review the resident's record for documentation of the resident's advance directives. Documentation must be available in the record for a directive to be considered current and binding.

Some residents at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether or not the new resident has ever created an advance directive (e.g., ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made in concert with the resident's closest family members or, in their absence or in case of conflict, through legal guardianship proceedings.

Coding: The following comments provide further guidance on how to code these directives. You will also need to consider State law, legal interpretations, and facility policy.

- The resident (or proxy) should always be involved in the discussion to ensure informed decision-making. If the resident's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS item only after the preference has been documented.

- If the resident's preference is in areas that require supporting orders by the attending physician (e.g., do not resuscitate, do not hospitalize, feeding restrictions, other treatment restrictions), check the MDS item only if the document has been recorded or after the physician provides the necessary order. Where a physician's current order is recorded, but resident's or proxy's preference is not indicated, discuss with the resident's physician and check the MDS item only after documentation confirming that the resident's or proxy's wishes have been entered into the record.

- If your facility has a standard protocol for withholding particular treatments from all residents (e.g., no facility staff member may resuscitate or perform CPR on any resident; facility does not use feeding tubes), check the MDS item only if the advanced directive is the individual preference of the resident (or legal proxy), regardless of the facility's policy or protocol.

Check all that apply. If none of the directives are verified by documentation in the medical records, check *NONE OF ABOVE*.

42 CFR 483.10 requires facilities to protect and promote the rights of each resident, including the right to "formulate an advanced directive." There is no regulatory text specifying a location for advanced directive information. Unless there are State codes or regulations regarding this matter, the method of communicating the information is up to the facility. If documentation is not available in the resident's clinical record, facility staff should be the source of this information, and surveyors will assess whether or not the staff knowledge and actions are in agreement with resident/family wishes. Some facilities elect to maintain the information in the resident's clinical record and may even verify the advanced directive was properly prepared, i.e., not witnessed by someone who will benefit from the resident's death. Make sure you are well aware of your facility's policies.

3.4 Clinical Items for the MDS

SECTION B.
COGNITIVE PATTERNS

Intent: To determine the resident's ability to remember, think coherently, and organize daily self-care activities. These items are crucial factors in many care planning decisions. Your focus is on resident performance, including a demonstrated ability to remember recent and long-past events and to perform key decision-making skills.

Questions about cognitive function and memory can be sensitive issues for some residents who may become defensive or agitated or very emotional. These are not uncommon reactions to performance anxiety and feelings of being exposed, embarrassed, or frustrated if the resident knows he or she cannot answer the questions cogently.

Be sure to interview the resident in a private, quiet area without distractions - i.e., not in the presence of other residents or family, unless the resident is too agitated to be left alone. Using a nonjudgmental approach to questioning will help create a needed sense of trust between staff and resident. Be cognizant of possible cultural differences that may affect your perception of the resident's response. After eliciting the resident's responses to the questions, return to the resident's family or others, as appropriate, to clarify or validate information regarding the resident's cognitive function over the last seven days. For residents with limited communication skills or who are best understood by family or specific caregivers, you will need to carefully consider their insights in this area.

- Engage the resident in general conversation to help establish rapport.

- Actively listen and observe for clues to help you structure your assessment. Remember - repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function.

- Be open, supportive, and reassuring during your conversation with the resident (e.g., "Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you").

If the resident becomes really agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information-gathering process does not need to be completed in one sitting but may be ongoing during the entire assessment period. Say to the agitated resident, for example, "Let's talk about something else now," or "We don't need to talk about

that now. We can do it later". Observe the resident's cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable.

It is often difficult to accurately assess cognitive function, or how someone is able to think, remember, and make decisions about their daily lives, when they are unable to verbally communicate with you. It is particularly difficult when the areas of cognitive function you want to assess require some kind of verbal response from the resident (e.g., memory recall). It is certainly easier to perform an evaluation when you can converse with a resident and hear responses from them that give you clues to how the resident is able to think (judgment), if he understands his strengths and weaknesses (insight), whether he is repetitive (memory), or if he has difficulty finding the right words to tell you what he wants to say (aphasia).

To assess an aphasic resident it is very important that you hone your listening and observation skills to look for non-verbal cues to the person's abilities. For example, for someone who is unable to speak with you but seems to understand what you are saying (expressive aphasia), the assessor could ask the resident the necessary questions and then ask him to answer you with whatever non-verbal means he is able to use (e.g., writing the answer; showing you the way to his room; pointing to a calendar to show you what month/season it is). Observe the resident at different times of the day and in different types of activities for clues to their functional abilities. Solicit input from the observations of others who care for the resident.

In all cases code the cognitive items with answers that reflect your best clinical judgment, realizing the difficulty in assessing residents who are unable to communicate. MDS Items B1, B4, B5 and B6 can be successfully coded without having to get verbal answers from the resident. Interdisciplinary collaboration will be helpful in conducting an accurate assessment.

B1. Comatose (7-day look back)

Intent: To record whether the resident's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

Coding: Enter the appropriate number in the box.

If the resident has been diagnosed as comatose or in a persistent vegetative state, code "**1**". ***Skip to Section G***. If the resident is not comatose or is semi-comatose, code "**0**" and proceed to the next Item (B2).

Clarification: ◆ Comatose (coma) is a pathological state in which neither arousal (wakefulness, alertness) nor awareness (cognition of self and environment) is present. The comatose person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

Sometimes residents who were comatose for a period of time after an anoxic-ischemic injury (i.e., not enough oxygen to the brain), from a cardiac arrest, head trauma or massive stroke, regain wakefulness but have no evidence of any purposeful behavior or cognition. Their eyes are open and they seem to be awake. They may grunt, yawn, pick with their fingers and have random movements of their heads and extremities. A neurological exam shows that they have extensive damage to both cerebral hemispheres. This state is different from coma, and if it continues, is called a persistent vegetative state. Both coma and vegetative state have serious consequences in terms of long-term clinical outcomes and care needs.

Many other residents have severe impairments in cognition that are associated with late stages of progressive neurological disorders such as Alzheimer's disease. Although such residents may be non-communicative, totally dependent on others for care and nourishment, and sleep a great deal of time, they are usually not comatose or in a persistent vegetative state as described above.

To prevent any resident from being mislabeled as such, it is imperative that coding of comatose reflect physician documentation of a diagnosis of either coma or persistent vegetative state.

B2. Memory (7-day look back)

Intent: To determine the resident's functional capacity to remember both recent and long-past events (i.e., short-term and long-term memory).

Process: **a. Short-Term Memory** - Ask the resident to describe a recent event that both of you had the opportunity to remember. Or, you could use a more structured short-term memory test. For residents with limited communication skills, ask staff and family about the resident's memory status. Remember, if there is no positive indication of memory ability, (e.g., remembering multiple items over time or following through on a direction given five minutes earlier) the correct response is "**1**", Memory Problem.

If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and the staff was unable to make a determination based on observation of the resident, use the "**-**" response to indicate that the information is not available because it could not be assessed.

Examples

Ask the resident to describe the breakfast meal or an activity just completed.

Ask the resident to remember three items (e.g., book, watch, table) for a few minutes. After you have stated all three items, ask the resident to repeat them (to verify that you were heard and understood). Then proceed to talk about something else - do not be silent, do not leave the room. In five minutes, ask the resident to repeat the name of each item. If the resident is unable to recall all three items, code "1". For persons with verbal communication deficits, non-verbal responses are acceptable (e.g., when asked how many children they have, they can tap out a response of the appropriate number).

b. Long-Term Memory - Engage in conversation that is meaningful to the resident. Ask questions for which you can validate the answers (from your review of record, general knowledge, the resident's family). For residents with limited communication skills, ask staff and family about the resident's memory status. If there is no positive indication of memory ability, the correct response is "**1**", Memory Problem.

If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and the staff was unable to make a determination based on observation of the resident, use the "**-**" response to indicate that the information is not available because it could not be assessed.

Example

Ask the resident, "Where did you live just before you came here?" If "at home" is the reply, ask, "What was your address?" If "another nursing facility" is the reply, ask, "What was the name of the place?" Then ask: "Are you married?" "What is your spouse's name?" "Do you have any children?" "How many?" "When is your birthday?" "In what year were you born?"

Coding: Enter the numbers that correspond to the observed responses.

Clarifications:

- Many persons with memory problems can learn to function successfully in a structured, routine environment. Observing resident function in multiple daily activities is only one aspect of evaluating short-term memory function. For example, a resident may remember to come to lunch, but may not remember what he/she ate. The short-term memory test described above is still an important component of the overall evaluation.

- When coding short-term memory, identify the most representative level of function, not the highest. Therefore, a resident with short-term memory problems 6 of the 7 days should be coded as "1". For many residents, performance varies. Staff must use clinical judgment to decide whether or not a single observation provides sufficient information on the resident's typical level of function.

B3. Memory/Recall Ability (7-day look back)

Intent: To determine the resident's memory/recall performance within the environmental setting. A resident may have intact social graces and respond to staff and others with a look of recognition, yet have no idea who they are. This item will enable staff to probe beyond first, perhaps mistaken, impressions.

Definition:

a. Current Season - Able to identify the current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).

b. Location of Own Room - Able to locate and recognize own room. It is not necessary for the resident to know the room number, but he or she should be able to find the way to the room.

c. Staff Names/Faces - Able to distinguish staff members from family members, strangers, visitors, and other residents. It is not necessary for the resident to know the staff member's name, but he or she should recognize that the person is a staff member and not the resident's son or daughter, etc.

d. That He/She Is In a Nursing Home - Able to determine that he/she is currently living in a nursing facility. To check this item, it is not necessary that the resident be able to state the name of the facility, but he/she should be able to refer to the facility by a term such as a "home for older people," a "hospital for the elderly," "a place where older people live," etc.

e. *NONE OF ABOVE* are recalled.

Process: Test memory/recall. Use information obtained from clinical records or staff. Ask the resident about each item. For example, "What is the current season?" "What is the name of this place?" "What is this kind of place?" If the resident is not in his or her room, ask, "Will you show me to your room?" Observe the resident's ability to find the way.

Coding: For each item that the resident can recall, check the corresponding answer box. If the resident can recall none, check *NONE OF ABOVE*.

B4. Cognitive Skills for Daily Decision-Making (7-day look back)

Intent: To record the resident's actual performance in making everyday decisions about tasks or activities of daily living.

Examples

Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary); making the correct decision concerning how to get to the lunchroom; acknowledging need to use a walker, and using it faithfully.

Process: Review the clinical record. Consult family and nurse assistants. Observe the resident. The inquiry should focus on whether or not the resident is actively making these decisions, and not whether staff believes the resident might be capable of doing so or not. Remember the intent of this item is to record what the resident is doing (performance). Where a staff member takes decision-making responsibility away from the resident regarding tasks of everyday living, or the resident does not participate in decision-making, whatever his or her level of capability may be, the resident should be considered to have impaired performance in decision-making.

This item is especially important for further assessment and care planning in that it can alert staff to a mismatch between a resident's abilities and his or her current level of performance, or that staff may be inadvertently fostering the resident's dependence.

Coding: Enter one number that corresponds to the most correct response.

0. Independent - The resident's decisions in organizing daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, values.

1. Modified Independence - The resident organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.

2. Moderately Impaired - The resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines.

3. **Severely Impaired** - The resident's decision-making was severely impaired; the resident never (or rarely) made decisions.

Clarifications:

- If the resident "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, Item B4 would be coded as "3" for Severely Impaired. If the resident attempts to make decisions, although poorly, code "2" for Moderately Impaired.

- Coding the following examples for MDS Item B4 "Cognitive Skills for Daily Decision-Making:"

  (1) If a resident seems to have severe cognitive impairment and is non-verbal, but usually clamps his mouth shut when offered a bite of food, would the resident be considered moderately or severely impaired?

  (2) If a resident does not generally make conversation or make his needs known, but replies "yes" when asked if he would like to take a nap, would the resident be considered moderately or severely impaired?

  These examples are similar in that the residents are primarily non-verbal and do not make their needs known, but they do make basic verbal or non-verbal responses to simple gestures or questions regarding care routines (e.g., comfort). More information about how the resident functions in his environment is needed to definitively answer the questions. From the limited information provided about these residents, one would gather that their communication is only focused on very particular circumstances, in which case it would be regarded as "rarely/never" in the relative number of decisions a person could make during the course of a week, and MDS Item B4 would be coded as "3", Severe Impairment. The assessor should determine if the resident would respond in a similar fashion to other requests made during the 7-day observation period. If such "decisions" are more frequent, the resident may be only moderately impaired or better.

B5. Indicators of Delirium - Periodic Disordered Thinking/Awareness
(7-day look back)

Intent: To record behavioral signs that may indicate that delirium is present. Frequently, delirium is caused by a treatable illness such as infection or reaction to medications.

The characteristics of delirium are often manifested behaviorally and therefore can be observed. For example, disordered thinking may be manifested by rambling, irrelevant, or incoherent speech. Other behaviors are described in the definitions below.

A recent change (deterioration) in cognitive function is indicative of delirium (acute confusional state), which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. However, when a resident has a pre-existing cognitive impairment or pre-existing behaviors such as restlessness, calling out, etc., detecting signs of delirium is more difficult. Despite this difficulty, it is possible to detect signs of delirium in these residents by being attuned to recent changes in their usual functioning. For example, a resident who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive. Or, conversely, one who is normally quiet and content may suddenly become restless and noisy. Or, one who is usually able to find his or her way around the unit may begin to get "lost."

Definitions: Examples of behaviors to be assessed and coded include the following:

a. Easily Distracted - Difficulty paying attention; gets sidetracked.

b. Periods of Altered Perception or Awareness of Surroundings - Moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day.

c. Episodes of Disorganized Speech - Speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought.

d. Periods of Restlessness - Fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out.

e. Periods of Lethargy - Sluggishness, staring into space; difficult to arouse; little body movement.

f. Mental Function Varies Over the Course of the Day - Sometimes better, sometimes worse; behaviors sometimes present, sometimes not.

Coding: Code for resident's behavior in the last seven days regardless of what you believe the cause to be - focusing on when the manifested behavior first occurred.

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

Case Example 1

Mrs. K is a 92 year old widow of 30 years who has severe functional dependency secondary to heart disease. Her primary nurse assistant has reported during the last two days Mrs. K has "not been herself." She has been napping more frequently and for longer periods during the day. She is difficult to arouse and has mumbling speech upon awakening. She also has difficulty paying attention to what she is doing. For example, at meals instead of eating as she usually does, she picks at her food as if she doesn't know what to do with a fork. Then stops and closes her eyes after a few minutes. Alternatively, Mrs. K has been waking up at night believing it to be daytime. She has been calling out to staff demanding to be taken to see her husband (although he is deceased). On 3 occasions Mrs. K was observed attempting to climb out of bed over the foot of the bed.

Indicators	Coding
a. Easily distracted	2 (present, new)
b. Periods of altered perception or awareness of surroundings	2 (present, new)
c. Episodes of disorganized speech	2 (present, new)
d. Periods of restlessness	2 (present, new)
e. Periods of lethargy	2 (present, new)
f. Mental function varies over the course of the day	2 (present, new)

Case Example 2

Mr. D has a history of Alzheimer's disease. His skills for decision-making have been poor for a long time. He often has difficulty paying attention to tasks and activities and usually wanders away from them. He rarely speaks to others, and when he does it is garbled and the contents are nonsensical. He is often observed mumbling and moving his lips as if he's talking to someone. Although Mr. D is often restless and fidgety this behavior is not new for him and it rarely interferes with a good night's sleep.

Indicators	Coding
a. Easily distracted	1 (present, not new)
b. Periods of altered perception or awareness of surroundings	1 (present, not new)
c. Episodes of disorganized speech	1 (present, not new)
d. Periods of restlessness	1 (present, not new)
e. Periods of lethargy	0 (behavior not present)
f. Mental function varies over the course of the day	1 (present, not new)